

Authors' Response to:

Review of Paulozzi, LJ, et al, "Lack of Evidence that Prescription Drug Monitoring Programs Decrease Deaths from Opioid Overdose"

Paula A. Berezansky

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Are the study objectives clearly stated and appropriate? (Yes, No, Unsure) Why?
Yes

Is the overall study design appropriate for the study objectives? (Yes, No, Unsure) Why? Yes

Are the methods and analysis plan appropriate for the study objectives? (Yes, No, Unsure) Why? Yes

Were the data analyzed in such a way to address the objectives of the study appropriately? (Yes, No, Unsure) Why? Yes

Are the study results presented and interpreted appropriately and completely? (Yes, No, Unsure) Why? Yes

Are the study conclusions, policy implications, and recommendations appropriate and complete? (Yes, No, Unsure) Why? Yes

Are there any other comments on the report?

p.4, PDMPs – The Harold Rogers' program is officially named the Harold Rogers Prescription Drug Monitoring Program. The first grants were awarded in fiscal year (FY) 2003. <http://www.ojp.usdoj.gov/BJA/grant/prescripdrugs.html>

Response: Changed the name and changed to FY 2003.

p.6, ARCOS – Which ARCOS data were used (i.e. cumulative distribution, retail distribution, retail distribution to pharmacies)?

Response: It was retail distribution, Report 2. This is now noted in text.

p.7, Hydrocodone Schedule III – I suggest stating that state PDMPs vary regarding the collection of Schedule III data.

Response: We added a sentence on page 11 saying that a few state PDMPs do not track Schedule III drugs at all. We also added a sentence on page 12 in the discussion of NY, TX, and CA that NY and TX did not track CS III during the study period.

p.11, Are any additional reasons, other than operating some of the oldest PDMPs in the country and the use of special prescription forms, attributed to CA, NY, and TX having lower rates of opioid prescribing?

Response: We say in the bottom paragraph of page 12 that other factors may be involved, eg, their handling of PDMP data, but we really don't know what may be affecting the opioid use numbers.

p.11, Tamper-proof prescription forms – The CA forms changed in 2005. According to information on the CA state government website, prior to 2005, the forms were not single-copy, but triplicate.

Response: Agreed. All 3 have single-copy now, but during the study period they had triplicate for some of the years. So we've revised the text to talk about special tamper-resistant paper forms rather than single-copy forms.

California Senate Bill 151 repeals a longstanding requirement for state-issued triplicate prescription forms. As of July 1, 2004, the Department of Justice will no longer produce or distribute triplicate prescription forms. In place of the triplicate, prescribers will use a tamper-resistant prescription pad available from private printing companies that have been approved by the Board of Pharmacy and Department of Justice

(http://www.pharmacy.ca.gov/consumers/prescribe_dispense.htm#timeline).

Triplicates Out - New Tamper-Resistant Security Prescriptions In!

The triplicate prescription form required to prescribe Schedule II medications is being replaced. On January 1, 2005, all written controlled substance prescriptions (for Schedules II-V) must be on the new, tamper-resistant prescription form (http://www.pharmacy.ca.gov/consumers/prescribe_dispense#triplicates).

I am not an expert on prescription forms, but I am curious regarding the use/non-use/consistency of specific prescription forms by state during the study's time frame, 1999-2005.

Response: See previous response. In addition, Idaho had special paper forms all 7 years, and Illinois had triplicate forms until 2001. As far as we know, use was mandatory in these states, and compliance was high. I don't know of anyone having studied the recent history of paper forms. Most of the literature is old.